Child Fatality Report

Report Identification Number: AL-17-034

Prepared by: New York State Office of Children & Family Services

Issue Date: Mar 14, 2018

This report, prepared pursuant to section 20(5) of the Social Services Law (SSL), concerns:

☐ A report made to the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) involving the death of a child.

☒ The death of a child for whom child protective services has an open case.

☐ The death of a child whose care and custody or custody and guardianship has been transferred to an authorized agency.

☐ The death of a child for whom the local department of social services has an open preventive service case.

The Office of Children and Family Services (OCFS) is mandated by section 20 of the SSL to investigate or cause for the investigation of the cause and circumstances surrounding the death, review such investigation, and prepare and issue a fatality report in regard to the categories of deaths noted above involving a child, except where a local or regional fatality review team issues a report, as authorized by law.

Such report must include: the cause of death; the identification of child protective or other services provided or actions taken regard to such child and child's family; any extraordinary or pertinent information concerning the circumstances of the child's death; whether the child or the child's family received assistance, care or services from the social services district prior to the child's death; any action or further investigation undertaken by OCFS or the social services district since the child's death; and as appropriate, recommendations for local or state administrative or policy changes.

This report contains no information that would identify the deceased child, his or her siblings, the parent, parents, or other persons legally responsible for the child, and any members of the deceased child's household.

By statute, this report will be forwarded to the social services district, chief county executive officer, chairperson of the local legislative body of the county where the child died and the social services district that had legal custody of the child, if different. Notice of the issuance of this report will be sent to the Speaker of the Assembly and the Temporary President of the Senate of the State of New York.

This report may **only** be disclosed to the public by OCFS pursuant to section 20(5) of the SSL. **It may be released by OCFS only after OCFS has determined that such disclosure is not contrary to the best interests of the deceased child's siblings or other children in the household.**

OCFS' review included an examination of actions taken by individual caseworkers and supervisors within the social services district and agencies under contract with the social services district. The observations and recommendations contained in this report reflect OCFS' assessment and the performance of these agencies.

Abbreviations

Relationships		
BM-Biological Mother	SM-Subject Mother	SC-Subject Child
BF-Biological Father	SF-Subject Father	OC-Other Child
MGM-Maternal Grand Mother	MGF-Maternal Grand Father	FF-Foster Father
PGM-Paternal Grand Mother	PGF-Paternal Grand Father	DCP-Day Care Provider
MGGM-Maternal Great Grand Mother	MGGF-Maternal Great Grand Father	PGGF-Paternal Great Grand Father
PGGM-Paternal Great Grand Mother	MA/MU-Maternal Aunt/Maternal Uncle	PA/PU-Paternal Aunt/Paternal Uncle
FM-Foster Mother	SS-Surviving Sibling	PS-Parent Sub
CH/CHN-Child/Children	OA-Other Adult	
Contacts		
LE-Law Enforcement	CW-Case Worker	CP-Case Planner
Dr.-Doctor	ME-Medical Examiner	EMS-Emergency Medical Services
DC-Day Care	FD-Fire Department	BM-Biological Mother
CPS-Child Protective Services		
Allegations		
FX-Fractures	II-Internal Injuries	L/B/W-Lacerations/Bruises/Welts
S/D/S-Swelling/Dislocation/Sprains	C/T/S-Choking/Twisting/Shaking	B/S-Burns/Scalding
P/Nx-Poisoning/ Noxious Substance	XCP-Excessive Corporal Punishment	PD/AM-Parent's Drug Alcohol Misuse
CD/A-Child's Drug/Alcohol Use	LMC-Lack of Medical Care	EdN-Educational Neglect
EN-Emotional Neglect	SA-Sexual Abuse	M/FTTH-Malnutrition/Failure-to-thrive
IF/C/S-Inadequate Food/ Clothing/ Shelter	IG-Inadequate Guardianship	LS-Lack of Supervision
Ab-Abandonment	OTH/COI-Other	
Miscellaneous		
IND-Indicated	UNF-Unfounded	SO-Sexual Offender
Sub-Substantiated	Unsub-Unsubstantiated	DV-Domestic Violence
LDSS-Local Department of Social Service	ACS-Administration for Children's Services	NYPD-New York City Police Department
PPRS-Purchased Preventive Rehabilitative Services	TANF-Temporary Assistance to Needy Families	FC-Foster Care
MH-Mental Health	ER-Emergency Room	COS-Court Ordered Services
OP-Order of Protection	RAP-Risk Assessment Profile	FASP-Family Assessment Plan
FAR-Family Assessment Response	Hx-History	Tx-Treatment
CAC-Child Advocacy Center	PIP-Program Improvement Plan	yo- year(s) old
CPR-Cardiopulmonary Resuscitation		

Case Information

Report Type: Child Deceased
Age: 5 year(s)
Jurisdiction: Schenectady
Gender: Female
Date of Death: 12/17/2017
Initial Date OCFS Notified: 12/19/2017

Presenting Information

The 5-year-old female SC died on 12/17/17 after being hospitalized for several days. Schenectady County Department of Social Services (SCDSS) had an open CPS investigation at the time of the SC's death. SCDSS received an SCR report on 12/10/17 that alleged, the Guardian of the SC (OA) was unable to appropriately care for the SC. The report stated on the evening of 12/10/17 the SC's head became wedged in an opening of a reclining chair while the OA was sitting in the chair. The OA allegedly leaned forward while the SC was in the chair, causing further harm. The SC became unconscious and was unresponsive for 30 minutes and required medical treatment. The SC was hospitalized as a result of the incident.

Executive Summary

This report concerns the death of the 5-year-old SC. The SC died during an open CPS Investigation with Schenectady County Department of Social Service (SCDSS). There was no subsequent SCR report made regarding the death of the SC as there was no suspicion of abuse or maltreatment. The initial SCR report was received by SCDSS on 12/11/17 after the SC was hospitalized due an incident that took place in the home. SCDSS submitted a 7065 form as notification of the SC's death on 12/17/17. SCDSS notified OCFS of the death on 12/18/17 via the telephone.

On 12/10/17 the SC was home watching a movie with the OA and a friend of the OA (OA2). The SC jumped up on a recliner where the OA was sitting. The SC normally climbed up the front on the recliner to sit on the OA's lap when she was seated. The SC's head fell into the opening between the foot rest and body of the recliner, while it was in a reclined position. The SC was unable to free herself. The OA and OA2 were also unsuccessful in freeing the SC from her position. A neighbor was called to the home and was able to free the SC. The SC was unresponsive and CPR was performed while 911 was called. EMS and LE arrived and the child was resuscitated and transported to the ER in an ambulance.

The SC was intubated and attached to a ventilator, while she underwent testing and medication administration. After 5 days the SC's condition deteriorated and test results revealed extensive oxygen depravation which caused brain damage. A Do Not Resuscitate Order (DNR) was signed and on 12/16/17 the SC was removed from life support equipment. The SC was unable to breathe independently and her death was declared on 12/17/17.

The official cause and manner of death were pending autopsy results. An autopsy was performed by the ME and the report was not completed at the time of this writing. LE did not pursue criminal charges, but their investigation remained open at the time of this writing.

Although the OA had custody of the SC since 2013, SCDSS made extensive efforts to contact the BM in the state where she resides. The BF of the SC was not listed on the birth certificate, but SCDSS made efforts to locate him, including checking the putative father registry. There were no SS, or other CHN in the home of the SC.

SCDSS was diligent in identifying and interviewing each individual that responded to the events in the SC's home the night of 12/10/17. There was detailed documentation in the case notes of their individual accounts regarding the incident. SCDSS also extensively documented medical records they received and reviewed.

SCDSS offered burial assistance and bereavement counseling services to the OA.

SCDSS made the appropriate determination to unsubstantiate the allegation of IG against OA regarding the fatal incident and subsequent death of the SC. SCDSS found no credible evidence that the OA failed to appropriately supervise the SC on the evening of the incident. When the OA and OA2 were unsuccessful in their attempts to free the SC, they immediately sought the help of neighbors. The SC was still conscious and verbal at that time; OA and OA2 thought the situation could be resolved without immediately notifying 911. On the basis of the facts presented, SCDSS determined the OA reacted in a manner that would be considered reasonable and within normal standards of parenting.

Findings Related to the CPS Investigation of the Fatality

Safety Assessment:

- **Was sufficient information gathered to make the decision recorded on the:**
  - **Safety assessment due at the time of determination?** Yes

Determination:

- **Was sufficient information gathered to make determination(s) for all allegations as well as any others identified in the course of the investigation?** Yes, sufficient information was gathered to determine all allegations.
- **Was the determination made by the district to unfound or indicate appropriate?** Yes

Was the decision to close the case appropriate? Yes

Was casework activity commensurate with appropriate and relevant statutory or regulatory requirements? Yes

Was there sufficient documentation of supervisory consultation? Yes, the case record has detail of the consultation.

Explain:
It was appropriate to close the case.

Required Actions Related to the Fatality

Are there Required Actions related to the compliance issue(s)? ☐Yes ☒No

Fatality-Related Information and Investigative Activities

Incident Information

Date of Death: 12/17/2017 **Time of Death:** 01:10 PM

Date of fatal incident, if different than date of death: 12/10/2017

Time of fatal incident, if different than time of death: Unknown

County where fatality incident occurred: Schenectady

Was 911 or local emergency number called? Yes
Time of Call: 11:06 PM
Did EMS respond to the scene? Yes
At time of incident leading to death, had child used alcohol or drugs? No
Child's activity at time of incident:

- ☐ Sleeping
- ☐ Working
- ☐ Driving / Vehicle occupant
- ☒ Playing
- ☐ Eating
- ☐ Unknown
- ☐ Other

Did child have supervision at time of incident leading to death? Yes
Is the caretaker listed in the Household Composition? Yes - Caregiver 1
At time of incident supervisor was: Not impaired.

Total number of deaths at incident event:
Children ages 0-18: 1
Adults: 0

Household Composition at time of Fatality

Household	Relationship	Role	Gender	Age
Deceased Child's Household	Deceased Child	No Role	Female	5 Year(s)
Deceased Child's Household	Other - Guardian	No Role	Female	66 Year(s)
Other Household 1	Mother	No Role	Female	27 Year(s)

LDSS Response

On 12/11/17 SCDSS received an SCR report regarding the SC. The report alleged the OA failed to provide adequate care to the SC.

SCDSS interviewed OA, OA2, first responders and friends that were at the SC's home the evening of the fatal events. SCDSS learned the evening on 12/10/17 at around 10:30PM, the SC was watching a movie with OA and OA2. The OA was sitting in a recliner in a reclined position and the SC jumped on the front of the recliner trying to climb up to the OA's lap. The SC's head got stuck in the opening between the body of the chair and the foot rest and the SC asked for help. The OA reported the SC's stomach was on the foot rest of the chair. The OA and OA2 reported they pulled the body of the SC, but they could not get her out. The OA said she climbed over the SC to get out of the chair. OA denied that she moved the reclining position of the chair. OA2 then went to the neighbor's home for help. The neighbor was unable to free the SC, and he called his son (OA3) that lived close by. OA3 was called at 11:02PM. OA3 freed the SC from the chair. OA3 began performing CPR on the SC and instructed OA and OA1 to call 911. The OA stated the SC stopped breathing 10 minutes before OA3 arrived. The first responders arrived and resuscitated the SC and she was transported to the ER via ambulance.

LE and first responders reported the same details as OA and OA2 regarding the events that took place the evening on 12/10/17. OA3 stated the SC's head was wedged in between the foot rest and body of the chair, with her chin under the foot rest. OA3 initially tried to break the chair to free her and when this did not work, he lifted her body in the air and got her free. OA3 reported this took about 5 minutes. There was a delay in the OA and OA2 calling 911 and OA2 said the first time she called the phone was busy. LE said this was possible but the second time it would have forwarded to another reception center. OA3 reported he told OA2 to call 911 after he freed the SC from the chair, as no one had yet called. The

call to 911 was made at 11:09PM. Based on the timeline OA and OA2 provided, LE and OA3 believed the SC was stuck in the chair for 15-30 minutes.

SCDSS called the source and hospital to inquire on the status of the SC. SCDSS learned the SC was transferred to a hospital that could provide specialized pediatric care. The SC was intubated and remained unconscious; the SC initially had a slight response to painful stimuli. Additionally, the SC had high blood pressure and there was concern of brain swelling. The SC was breathing over the ventilator, but believed to have suffered severe oxygen deprivation during the fatal incident. The SC had petechiae on her face, which indicated there was some sort of asphyxiation. While hospitalized the SC's condition worsened. The SC was no longer able to breathe over the ventilator and a DNR order was signed. The SC never regained consciousness and after testing, the dr. reported she suffered irreversible brain damage. On 12/16/17 the child was removed from life support and died on 12/17/17 at 1:10PM.

The SC had no SS and there were no other CHN living in the home. SCDSS learned OA had custody of the SC since 2013. The SC had no contact with her BM since 2013, when the BM left the state of New York. SCDSS made extensive efforts to contact the BM through direct contact with LE in the state where she resided and Facebook. The BM did not respond to SCDSS, but did reach out to the OA on Facebook after the SC died. SCDSS attempted to find the SC's BF, but were unable to get this information after exhausting all known sources.

SCDSS reviewed the medical records of the SC from the time of her birth. The SC was on medication and the OA reported the SC took this medication as prescribed. The SC's pediatrician reported she received appropriate medical care and they had no concerns. SCDSS also contacted the SC's school and there were no concerns for the OA's care of the SC.

Official Manner and Cause of Death

Official Manner: Pending
Primary Cause of Death: Undetermined if injury or medical cause
Person Declaring Official Manner and Cause of Death: Medical Examiner

Multidisciplinary Investigation/Review

Was the fatality reviewed by an OCFS approved Child Fatality Review Team?No

CPS Fatality Casework/Investigative Activities

	Yes	No	N/A	Unable to Determine
All children observed?	☐	☐	☒	☐
When appropriate, children were interviewed?	☐	☐	☒	☐
Contact with source?	☒	☐	☐	☐
All appropriate Collaterals contacted?	☒	☐	☐	☐
Was a death-scene investigation performed?	☒	☐	☐	☐
Coordination of investigation with law enforcement?	☒	☐	☐	☐
Was there timely entry of progress notes and other required documentation?	☒	☐	☐	☐

Fatality Safety Assessment Activities

	Yes	No	N/A	Unable to Determine
Were there any surviving siblings or other children in the household?	☐	☒	☐	☐

Legal Activity Related to the Fatality

Was there legal activity as a result of the fatality investigation? There was no legal activity.

Services Provided to the Family in Response to the Fatality

Services	Provided After Death	Offered, but Refused	Offered, Unknown if Used	Not Offered	Needed but Unavailable	N/A	CDR Lead to Referral
Bereavement counseling	☒	☐	☐	☐	☐	☐	☐
Economic support	☐	☐	☐	☐	☐	☒	☐
Funeral arrangements	☐	☐	☐	☐	☐	☒	☐
Housing assistance	☐	☐	☐	☐	☐	☒	☐
Mental health services	☐	☐	☐	☐	☐	☒	☐
Foster care	☐	☐	☐	☐	☐	☒	☐
Health care	☐	☐	☐	☐	☐	☒	☐
Legal services	☐	☐	☐	☐	☐	☒	☐
Family planning	☐	☐	☐	☐	☐	☒	☐
Homemaking Services	☐	☐	☐	☐	☐	☒	☐
Parenting Skills	☐	☐	☐	☐	☐	☒	☐
Domestic Violence Services	☐	☐	☐	☐	☐	☒	☐
Early Intervention	☐	☐	☐	☐	☐	☒	☐
Alcohol/Substance abuse	☐	☐	☐	☐	☐	☒	☐
Child Care	☐	☐	☐	☐	☐	☒	☐
Intensive case management	☐	☐	☐	☐	☐	☒	☐
Family or others as safety resources	☐	☐	☐	☐	☐	☒	☐
Other	☐	☐	☐	☐	☐	☒	☐

History Prior to the Fatality

Child Information

Did the child have a history of alleged child abuse/maltreatment?	Yes
Was there an open CPS case with this child at the time of death?	Yes
Was the child ever placed outside of the home prior to the death?	Yes
Were there any siblings ever placed outside of the home prior to this child's death?	No
Was the child acutely ill during the two weeks before death?	No

CPS - Investigative History Three Years Prior to the Fatality

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
12/11/2017	Deceased Child, Female, 5 Years	Other - Guardian, Female, 66 Years	Inadequate Guardianship	Unfounded	No

Report Summary:
An SCR report was received alleging the OA was not mentally capable of caring for the SC. The report alleged on 12/10/17 at about 11:00 pm the SC jumped on the OA while the OA was sitting in a reclining chair. The SC fell between the opening and foot rest of the chair and her head was stuck. The OA leaned forward in the chair and worsened the situation. The SC was unresponsive for about 30 minutes and required emergency treatment. The SC was resuscitated and able to breath slightly on her own, but never regained consciousness.

Determination: Unfounded **Date of Determination:** 02/09/2018

Basis for Determination:
SCDSS found that the OA had adequately supervised the SC on the night of the incident. The OA had cared for the SC for several years and the SC had several service providers. All collateral contacts made denied any concerns that the OA was able to appropriately care for the SC.

OCFS Review Results:
SCDSS jointly investigated with LE. SCDSS contacted all first responders, family members, the SC's school and the SC's pediatrician to gather information. SCDSS extensively documented interviews with the OA, family members and collateral contacts. The notes were entered contemporaneously and regular supervisor reviews were documented. SCDSS exhausted all options to locate the BM of the SC.

Are there Required Actions related to the compliance issue(s)? ☐Yes ☒No

Date of SCR Report	Alleged Victim(s)	Alleged Perpetrator(s)	Allegation(s)	Status/Outcome	Compliance Issue(s)
08/14/2015	Deceased Child, Female, 3 Years	Unrelated Home Member, Female, 60 Years	Inadequate Guardianship	Unfounded	Yes
	Deceased Child, Female, 3 Years	Other Adult - SC's Guardian, Female, 64 Years	Excessive Corporal Punishment	Unfounded	
	Deceased Child, Female, 3 Years	Other Adult - SC's Guardian, Female, 64 Years	Inadequate Guardianship	Unfounded	

Report Summary:
An SCR report was received alleging that the OA was physically aggressive to the SC. The report alleged the OA became agitated with the SC and lifted her up and threw her across the room while yelling at the child. There was an unrelated home member (UHM) present that failed to intervene to protect the SC. The UHM slapped the SC on the hand and also yelled at her. The SC did not sustain any visible marks as a result of the event.

Determination: Unfounded	**Date of Determination:** 09/09/2015

Basis for Determination:
The OA and UHM denied the allegations and SCDSS observed the SC to be free of marks and bruises throughout the investigation. SCDSS discovered there were no surveillance cameras in the public building where the reported events took place, so they were unable to review the events of the day the incident occurred. The OA reported the SC often had tantrums when she became frustrated and physically act out. The OA and suggested this occurred the day of the incident and may have been misconstrued by witnesses. There was no credible evidence to support the allegations.

OCFS Review Results:
The source was contacted and safety and risk assessments completed. SCDSS spoke with the pediatrician and there were no concerns for the SC. SCDSS provided the OA with respite options for the SC in the event the MGM was overwhelmed in caring for the SC in the future. The OA and SC had an open voluntary Preventive Services Case at the time of the investigation and it remained open at investigation closing.

Are there Required Actions related to the compliance issue(s)? ☒ Yes ☐ No

Issue:
Failure to provide notice of report

Summary:
The initial household composition reported to the SCR was inaccurate and SCDSS modified the composition to reflect all members of the SC's home. After adding household members, a notice of existence letter was not sent to all those listed on the report.

Legal Reference:
18 NYCRR 432.2(b)(3)(ii)(f)

Action:
SCDSS will send a notice of existence letter to all adults named in a report whether they are included on the oral report or added during the investigation.

[redacted]

CPS - Investigative History More Than Three Years Prior to the Fatality

An SCR report was received on 7/15/12 and determined on 9/17/12. The allegations of IG and LS Unsub against the BM regarding the SC.

An SCR report was received on 1/10/13 and determined on 1/31/13. The allegations of IG Sub against the BM regarding the SC.

Known CPS History Outside of NYS

There is no known history outside of New York State.

Preventive Services History

A voluntary Preventive Services case was opened 8/12/12 for the SC and her BM, because the SC had developmental delays which required supportive services and there was concern the BM would not be able to follow through with the services for the child without assistance and support. SCDSS monitored the BM's participation with services required for the SC. These services included a visiting nurse, early intervention, physical therapy and Healthy Schenectady Family Program. In January of 2013 the BM moved out of the state and made a plan to leave the SC in the informal care of a

family friend (OA). OA filed for custody of the SC in February of 2013 and received full custody in July of 2013. The Preventive Services case continued to assist OA in meeting the SC's needs for services. OA was cooperative with service providers throughout the open case. OA requested her Preventive Case be closed as she continued to be cooperative with the service providers for the SC. There were no safety concerns for the SC and the case closed on 3/3/16.

Casework Contacts

	Yes	No	N/A	Unable to Determine
Were face-to-face contacts with the child in the child's placement location made with the required frequency?	☐	☐	☒	☐

Legal History Within Three Years Prior to the Fatality

Was there any legal activity within three years prior to the fatality investigation? There was no legal activity

Recommended Action(s)

Are there any recommended actions for local or state administrative or policy changes? ☐Yes ☒No

Are there any recommended prevention activities resulting from the review? ☐Yes ☒No